



Community Development Department • 500 Castro Street • Post Office Box 7540 • Mountain View, California 94039-7540
 PHONE 650-903-6379 • FAX 650-962-8052

Community Development Block Grant/HOME Investment Partnership Program Report Form

Fiscal Year: 2010-11 Quarter (Check one): 1st _____ 2nd: _____ 3rd: _____ 4th: _____

Agency/Organization: _____

Project: _____

Contact Person/Title: _____

Phone: _____ Email: _____

A. Project Progress

Indicate the goals/objectives planned for the quarter as stated in the original application for funds and what was achieved:

Activity	Outcome	Total # to be Served	Goals Per Quarter			
			1 st	2 nd	3 rd	4 th
			Achieved Per Quarter			
Activity	Outcome	Total # to be Served	Goals Per Quarter			
			1 st	2 nd	3 rd	4 th
			Achieved Per Quarter			

Indicate goals/objectives not attained and what steps have project management taken or proposed to resolve problems in achieving goals.

B. Clients Served

Please report the number of unduplicated clients served in Mountain View.

	Served this Quarter	Year to Date Total
Mountain View persons/households (circle one)		
Female Headed Households		
Male Headed Households		

	Served this Quarter		Year to Date Total	
Clients by Income Group (for Mountain View Clients)				
Extremely Low Income (0-30% AMI)				
Very Low Income (31-50% AMI)				
Low Income (51-80% AMI)				
Moderate Income (81-120% AMI)				
Above Moderate Income (120%+ AMI)				
Total				
Clients by Special Needs Population (for Mountain View Clients)				
Youth (0 to 18 years)				
Adults (19 to 62 years)				
Seniors (63+ years)				
Disabled Individuals				
Other Special Needs				
Clients by Race/Ethnicity (for Mountain View Clients)				
	Total	Also Hispanic	Total	Also Hispanic
White				
Black/African American				
Asian				
American Indian/Alaskan Native				
Native Hawaiian/Pacific Islander				
American Indian/Alaskan Native and White				
Asian and White				
Black/African American and White				
American Indian/Alaskan Native and Black/African American				
Other Multi-Racial				
Total				

For extremely low-, very low-, or low- income beneficiaries, please indicate how eligibility was determined and verified.

Person who Prepared Form/Title: _____ Phone Number: _____

Signature: _____ Date: _____

Signature of Authorized Person (Supervisor): _____

Name/Title: _____